Washington State Department of Social & Health Services

LOCAL OFFICE	TELEPHONE NUMBER
CASE NUMBER	DATE

WORKING CONNECTIONS CHILD CARE DENIAL/ TERMINATION NOTICE

FOLD

The Department of Social and Health Services (DSHS) payments to your child care provider will stop for any child care provided after this date. Please talk with your provider to discuss future child care payments.

A. ☐ On _____ you asked for help with child care under the WCCC program. We will not be able to help you because (per WAC 388-290):

- ☐ You withdrew your request for child care assistance.
- ☐ You do not have an eligible child, under WAC 388-290-0015.
- ☐ Your activities do not meet the requirements in WAC 388-290-0040, 0045, or 0050.
- ☐ You are financially eligible for child care subsidies, however, your provider is disqualified under WAC 388-290-0130. You must select another provider. If you do not provide new provider information by _____, we will determine that you have withdrawn your request for child care assistance.
- ☐ Your income is above the maximum allowable Federal Poverty Level (FPL) for program eligibility, per WAC 388-290-0010.
- ☐ You did not provide the necessary information to determine your eligibility.
- ☐ Other: _____

B. ☐ Your Working Connections Child Care WCCC) eligibility will end _____. Payments for child care subsidies will stop on this date.

- ☐ You withdrew your request for child care assistance.
- ☐ You no longer have an eligible child under WAC 388-290-0015.
- ☐ Your activities do not meet the requirements in WAC 388-290-0040, 0045, or 0050.
- ☐ You have failed to pay, or make arrangements to pay, your required copayment.
- ☐ You are financially eligible for child care subsidies, however, your provider is disqualified under WAC 388-290-0130. You must select another provider. If you do not provide new provider information by _____, we will determine that you have withdrawn your request for child care assistance.
- ☐ Your income is above the maximum allowable Federal Poverty Level (FPL) for program eligibility, per WAC 388-290-0010.
- ☐ Other: _____

If you disagree with this decision, you may request a Fair Hearing by contacting this office or write to Office of Administrative Hearings, P O Box 42489, Olympia, WA 98507-2465. You must request your fair hearing within 90 days of the date you receive this letter. At the hearing, you have the right to represent yourself, be represented by an attorney or by any other person you choose. You may be able to get free legal advice or representation by contacting an office of legal services. You may be eligible to receive continued benefits pending the outcome of a Fair Hearing.

If you have any questions, please contact me at _____.

AUTHORIZING WORKER'S NAME

AUTHORIZING WORKER'S TELEPHONE/FAX NUMBER

MEDICAL FOR YOUR CHILDREN

Did you know that you could get medical and dental coverage for your children? There is no waiting list and it's as easy as **1 - 2 - 3**!

1. Are you receiving any other type of assistance through the state, such as food stamps or cash assistance?
   - **YES:** Call the financial worker in charge of your case and request medical coverage for your child(ren).
   - **NO:** Call the toll free telephone number for Children's Medical assistance at 1-800-204-6429.
2. Provide the worker with the information they need to tell if you are eligible. They may already have this or be able to take it over the telephone.
3. Receive the medical card in the mail.

Don't wait - medical coverage for you child is as close as a phone call away!